
Pay it
FORWARD
#KIDKNEWS3
KIDK 3
EYEWITNESS
NEWS

Start typing drug name

Drug Search

Drug Pricing Calculator

Find drug prices and pharmacies

search »

Get Your NeedyMeds Drug Discount Card!

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Your Guide to Medical Websites

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Medication Reminders On-The-Go App

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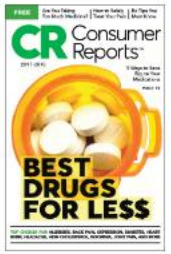
It's Back in Print!

Consumer Reports *Best Drugs for Less* Booklets



Through our partnership with Consumer Reports, NeedyMeds is offering the new 2017-2018 *Best Drugs for Less* print edition booklets in English. Visit our Subscription Center to order your copy. A mobile-friendly digital version is available in Spanish. The *Best Drugs for Less* highlights CR's best advice for saving money on your meds, which drugs you should take for common conditions, the questions you should ask your doctor, and much more.

Over $191,032,210.45 Saved
With NeedyMeds Drug Card

HealthWeb Navigator

Can You Trust What You Read on Medical Websites? Not Always!

NeedyMeds announces a website — HealthWeb Navigator. This beta version has reviews of health-related websites to help you find the best, most medically reliable information. Our medically-trained reviewers evaluate the site for medical accuracy and completeness while our usability reviewers check out how easy it is to use. Learn about how to become a volunteer reviewer.

1 2 3 4 5 6 7 8 9 10

Subscription Center

- Subscribe to Services
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Sponsors

Calendar of Events

March 2017

mon	tue	wed	thu	fri	sat	sun
		1	2	3	4	5

9:29 AM
3/16/2017

Patient Info
Emergency Info
Household
Edit Household
View Members
Income Detail
Inc Summary
Insurance
Medical History
Referrals
Add Referral
View Referrals
Special Programs
Visits
Add Visit
Edit Visit
View Medications
Support
Support Docs
Help Desk
DELETE Patient
Log Out

Patient Demographics for Jane Doe

Help

Patient Reports | Patient Chart | Visit Chart

Format 999-99-9999 | Patient RxAssistPlus ID 1325912

Social Security No.	123-45-6789	Employment Status	Employed
Gender	Female	Occupation	Trainer
Marital Status	Single	Employer	
Ethnicity	-Select-	Education Level	-Select-
Race	-Select-	Primary Language	English
Veteran	☐	Interpreter Needed	☐
U S Citizen	Yes	Referral Source	-Select-
U S Resident	-Select-		
Clinic Patient ID		Account No.	
Date of Birth	01/05/1995	Date of Death	
Date Disenrolled		Date Last Updated	07/28/2016
Reason Disenrolled			
Email Address			

Comment: Drug Allergies:

Diagnosis:

Explanation of Patient's need

Print Report

Add Address | Edit Address | Update Demographics

Add Phone Number | Edit Phone Number | Return to Patient Info

Return to Select Patient

RxAssist Plus PRESCRIPTION ASSISTANCE.

Patient Info
Demographics
Emergency Info
Household
Insurance
Medical History

Referrals
- Add Referral
- View Referrals

Special Programs

Visits
- Add Visit
- Edit Visit
- CPT Codes
- Diagnosis
- ICD-9 Codes
- ICD-10 Codes
- Provider Serv.
- New PAP Med
- Non PAP Med
- View Medications
- Vital Signs

Visit Services
- Appliances
- Counseling
- Dental Procs
- Injections

Select a Medication for Jane . Doe

Search By: Drug ▾ Search For: humulin Search

Any medication highlighted in yellow is only available to currently enrolled patients.

Any medication highlighted in light blue is part of a discount program (Co-Pay)

Add	Info	Brand Name	Generic Name	Program Name	Company
Add	Info	Humulin 50/50	isophane human insulin (rDNA); human insulin (rDNA)	Lilly Cares	Lilly
Add	Info	Humulin 70/30 Pen	isophane human insulin (rDNA); human insulin (rDNA)	Lilly Cares	Lilly
Add	Info	Humulin 70/30 Vial	sophane human insulin (rDNA); human insulin (rDNA)	Lilly Cares	Lilly
Add	Info	Humulin N Injection	NPH human insulin (rDNA)	Lilly Cares	Lilly
Add	Info	HUMULIN N KWIKPEN	Insulin (Human Recombinant)	Lilly Cares	Lilly
Add	Info	Humulin R Injection	Regular human insulin (rDNA)	Lilly Cares	Lilly
Add	Info	Humulin R U-500	CONCENTRATED INSULIN REGULAR HUMAN	Lilly Cares	Lilly
Add	Info	HUMULIN R U500 KWIKPEN	human insulin (rDNA origin)	Lilly Cares	Lilly

Lilly Cares Foundation Patient Assistance Program
PO Box 13185
La Jolla, CA 92039
1-800-545-6962 Fax: (844) 431-6650
www.LillyCares.com

Patient Section

Patient Name: (Last) Doe (First) Jane (MI) _____

Address: 123 Training Street

City: IdahoFalls State: ID Zip: 83001 Date of Birth: 1 / 5 / 1955
Month Day Year

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Patient Income Information

Number of family members living in your household: 1

Total household annual (yearly) adjusted gross income: 96000

1. **Proof of income—send copies only, no originals**: Send at least 1 document that shows your income or no income—such as documents listed below:
   - Copy of last year's Federal Income Tax return
   - Copy of current pay stubs or earnings statements
   - Copy of Social Security Income yearly benefit statement
   - Copy of W-2 or 1099 Form
   - Copy of unemployment benefit statement
   - Copy of statements of interest, dividends, or other income
2. **Additional proof of out-of-pocket pharmacy spend required for Medicare Part D patients (except Forteo and Taltz patients)**: Send proof that you have spent $1,100 (except Forteo and Taltz patients) on prescriptions this year. This can be an Explanation of Benefits (EOB) statement or summary from your pharmacy where you get your prescriptions filled.

If you do not know which documents to send, please call Lilly Cares at 1-800-545-6962.

Optional Text Message Notification of Approval

If your application is **approved**, we can send you a text message. The text message is optional. You can participate in Lilly Cares without signing up for the text message.

When you sign up for the text message, you must agree to the following conditions:

- Lilly Cares will send only one message. It will be an autodialed, pre-recorded message. (Standard text message and data rates apply.)
- Be aware that anyone who can open your phone might see your text message.
- The text message is NOT a reminder to take your medication. You are responsible to take your medication as prescribed.
- Do NOT report product complaints or adverse events (like side effects) by text message. To report these, please call The Lilly Answers Center at 1-800-LillyRx (1-800-545-5979).

To receive a text message, you must provide your cell phone number: _____

Patient Certification (Agreement)

I certify (agree) that the following statements are true:

- I am a permanent, legal resident of the United States.
- I am **NOT** enrolled in or eligible for Medicaid or Veteran's Administration benefits. (Humatrope patients may be eligible.)
- If I am a Medicare Part D patient (except Forteo and Taltz patients), I have spent $1,100 on prescriptions this year.
- My healthcare provider prescribed a Lilly medication in Group A and I am eligible for and have enrolled in Medicare Part D **OR** have no insurance.
- My healthcare provider prescribed a Lilly medication in Group B and I am eligible for and have enrolled in Medicare Part D **OR** have no insurance **OR** my insurance does not cover the Lilly medication.

I consent to the sharing, use, and receipt of information about me, as described below:

To run Lilly Cares, Lilly Cares needs some information about you. When you sign below, you are authorizing any pharmacy, healthcare provider, and or others who are in possession of your health information to share information about you with Lilly Cares, Eli Lilly & Company, and their affiliates, employees, agents, vendors, and business partners who may be assisting with the administration of Lilly Cares ("Receiving Entities"), including health information; in addition, you understand and are authorizing the Receiving Entities to share, use, and disclose your information for the purposes of operating the program.

The Receiving Entities may receive, share, and use the following information:

- Information in this application
- Information about your medical conditions, treatment, current and future medications, and insurance information
- Other information the Receiving Entities may obtain to operate Lilly Cares
- The Receiving Entities may share your information with your healthcare providers and pharmacists
- Your healthcare providers and pharmacists may share your information with the Receiving Entities
- The Receiving Entities may share your information with the Centers for Medicare and Medicaid Services ("CMS") and/or your Medicare Part D Plan Administrator. This will be consistent with the terms of any Data Sharing Agreement agreed upon by the Receiving Entities and CMS or your Medicare Part D Plan.

The Receiving Entities may share your information for the following purposes:

- To review your application and to contact you or your healthcare provider, if necessary, for that review
- To help operate Lilly Cares and for the Receiving Entities' internal purposes involving other patient assistance and charitable programs
- To your pharmacies and healthcare providers relating to your participation in Lilly Cares, including personal information and information about your prescription medications

Patient Certification (Agreement)--Continued

By my signature below, I also agree to the following:

- If I am **NOT** a Medicare Part D patient, I understand that my authorization to release my Protected Health Information ("PHI") enables a healthcare provider relying on this authorization to release my PHI to the Receiving Entities for one year from the date it is signed, and then I need to apply again to Lilly Cares.
- If I am a Medicare Part D participant, I understand that my authorization to release my PHI enables a healthcare provider relying on this authorization to release my PHI to the Receiving Entities for the remainder of this calendar year that it is signed, and then I need to apply again to Lilly Cares.
- I understand that if my information is shared in this manner, federal and state privacy laws may no longer protect my PHI and may not prohibit its further disclosure; however, the Receiving Entities have committed to use and disclose my PHI only as stated in this form.
- I understand if I do not sign or refuse to sign this form, I will not be eligible for Lilly Cares.
- I understand that I can cancel my consent at any time by sending a written notice to Lilly Cares at the address on this application. If I cancel my consent, I will no longer qualify for Lilly Cares. My healthcare providers will no longer share my PHI with the Receiving Entities after the date that the Receiving Entities receive and process my cancellation letter, but this will not affect information or disclosures shared before that time. Additionally, once my cancellation is received and processed by the Receiving Entities, my participation in Lilly Cares will be terminated, and after my participation is terminated, the Receiving Entities will only maintain and use my information for legal and regulatory purposes.
- I agree to follow the rules and conditions of Lilly Cares.
- I have been provided a copy of this authorization.
- I understand that Lilly Cares will decide if I qualify for this program. I understand that my application might not be approved.
- I will not submit any claim for reimbursement to any third party insurer for any product provided to me under Lilly Cares.
- If I am in Medicare, I will not claim any true-out-of-pocket cost from my Medicare Part D Plan for the value of the product given to me under Lilly Cares.
- If I am in Medicare, I understand that it is my responsibility to let my Medicare Part D Plan know about my enrollment in Lilly Cares.
- I understand Lilly Cares may change or end at any time without advance notice.
- I understand and agree that if a Receiving Entity asks, I will provide documentation that proves the information I have certified in this application is true, correct, and complete.
- **I understand that the Lilly Cares Foundation does not charge a fee for participation in Lilly Cares. The Lilly Cares Foundation is not affiliated with third parties who charge a fee for help with enrollment or medication refills. I am not required to use a third party who charges a fee to help with my enrollment, and if I use a third party who charges a fee to help with my enrollment or refills of my medication, this money is not paid to the Lilly Cares Foundation.**

Patient or Legal Guardian Signature:_____ **Date:** _____

Signature Required

Lilly Cares Foundation Patient Assistance Program
PO Box 13185
La Jolla, CA 92039
1-800-545-6962 Fax: (844) 431-6650
www.LillyCares.com

Healthcare Provider/Prescriber Section

Name of Lilly Cares applicant: JaneDoe Date of Birth: 01/05/1995

Healthcare provider/prescriber: MsRebeccaNewby (circle: M.D. D.O. N.P. P.A.)

Mailing address of healthcare provider: 2088E.25th Street

City: IdahoFalls State: ID Zip: 83404 Suite number: _____

(Note: Lilly Cares cannot ship to a P.O. Box. Lilly Cares medications are shipped to the healthcare provider's office, with the exception of Forteo, Humatrope, and Taltz, which are dispensed to the patient's home by Covance Specialty Pharmacy, unless otherwise specified by prescriber.)

Phone: (208) 5287655 Fax: (208) 5249390

State License #: PA818 Expiration date: 6302017

DEA #: MN2053382 Expiration date: 12/31/2017

(Required for requests of controlled substances)

Prescription and Refill Information: Completion of this section is <u>OPTIONAL</u> for the healthcare provider/prescriber, PROVIDED an actual hard copy prescription is submitted with the application. Forteo, Humatrope, and Taltz REQUIRE an actual hard copy prescription with the healthcare provider's/prescriber's signature. For your convenience, a Forteo, Humatrope, and Taltz prescription template can be found on the Lilly Cares website Resource page (www.LillyCares.com) or will be faxed to you during the application review process.

Patient Name: JaneDoe Patient DOB: 01/05/1995

Product Requested: Cymbalta Strength: _____

Sig: _____

If prescribing insulin: Units of insulin per dose: _____ Max. units of insulin per day: _____

Quantity: _____ (max 4-month supply) Date: _____

Signature: _____ _____

Dispense as written Substitution/brand exchange permitted

Prescriber must manually sign. Rubber stamps, signature by other office personnel for the prescriber, and computer-generated signatures will not be accepted.

Medication orders may be written for up to a 1-year supply, subject to program eligibility limits. Up to a 120-day supply is available in each shipment, unless a lesser amount is prescribed or provided per program guidelines.

Refills: A Lilly Cares Refill Authorization Form is located at the www.LillyCares.com Resource page which may be completed and faxed to Lilly Cares, or a refill can be requested by calling 1-800-545-6962. If the prescription has not changed from the original approved application, the refill request will be processed. If any part of the prescription has changed, a new prescription will be required. If the prescriber has changed, the new prescriber will complete and sign the Healthcare Provider/Prescriber Section of the Lilly Cares application and provide a new prescription.

Healthcare Provider's/Prescriber's Confirmations and Agreements:

The Lilly Cares Foundation agrees, to the extent consistent with its exempt purposes, qualified under Section 170 (e)(3) of the Internal Revenue Code, and authorized by Lilly Cares policies, to provide medicines, prescription drugs, and other pharmaceutical products, medical supplies, and property (the "Medications") to the prescriber (the "Prescriber") for the sole purpose of caring for the ill, needy, indigent, and/or infants in the United States (the "Qualifying Patients").

By signing below, I (the Prescriber) agree to the following terms and conditions:

- I will accept the Medication from Lilly Cares (except Forteo, Humatrope, and Taltz when dispensed to the patient home) and deliver the Medication only to the Qualifying Patient named on this form at no charge of any kind. I will not use any of the Medication for any other purpose. This Medication will not be offered for sale, trade, or barter; returned for credit; nor will reimbursement be sought or claims be made for the Medication to any third party, including, but not limited to Medicare, Medicaid, or any benefit provider.
- I have made my patient aware that I am releasing their personal health information to Lilly Cares for treatment purposes.
- I will give Lilly Cares 90 days advance notice if I need to assign this agreement, in full or in part, to another Prescriber.
- I am licensed to practice and dispense medicine, including the Medication, and will comply with and abide by my state practitioner dispensing laws for authorized prescribers in the state in which I am prescribing, receiving, storing, and dispensing this Medication to the above Qualifying Patient.
- Lilly Cares has the right to contact the Qualifying Patient directly to make sure that the Medication was received.
- Lilly Cares has the right to revise or terminate the program at any time.
- All the Medications I have ever received from Lilly Cares were distributed only to Qualifying Patients.
- I agree to properly dispose of unused Medication.

My signature below attests to my understanding and agreement to the above program requirements.

Prescriber Signature:_____ Date: _____

Name of Lilly Cares applicant: JaneDoe_____ DOB: 01/05/1995

Lilly Cares
P.O. Box 13185
La Jolla, CA 92039
www.LillyCares.com
Phone: 1-800-545-6962
Fax: 1-844-431-6650

Lilly Cares Refill Authorization Form

Patient Name: Jane Doe

Address: 123 Training Street, , Idaho Falls, ID 83001

DOB: 01/05/1995 **DATE:** _____

Lilly product: Cymbalta **Strength:** _____

Sig: _____
(If insulin, please include maximum daily dose)

Quantity to dispense: _____ **(max. 4-month supply)**
Please follow your state's regulation regarding the issuance of prescriptions.

Healthcare Provider's Attestations and Agreement to Participate in Lilly Cares Patient Assistance Program:
Lilly Cares agrees, to the extent consistent with its exempt purposes, qualified under Section 170(e)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), and authorized by Lilly Cares policies, to provide medicines, prescription drugs, and other pharmaceutical products, medical supplies, and property (the "Medications") to the prescriber (the "Healthcare provider") for the sole purpose of caring for the ill, needy, indigent, and/or infants in the United States (the "Qualifying Patients"). The Healthcare provider agrees to accept the Medications from Lilly Cares and deliver the Medications only to Qualifying Patients at no charge of any kind and further agrees not to use any of the Medications for any other purpose. The Healthcare provider agrees to provide Lilly Cares ninety (90) days advance notice of any proposed assignment, in full or part, of this agreement.
My signature immediately below attests to my understanding and agreement to the above Program requirements. I further attest that I am licensed in the state in which I am prescribing, receiving, storing, and dispensing this Medication to the above patient and will comply with and abide by my State Practitioner dispensing laws for authorized prescribers in the states in which I am prescribing, receiving, storing and dispensing Medications. I further attest that if Medications are received from Lilly Cares as a result of this application, I will accept such Medications and Medications will only be provided to the patient named on this form at no charge. I further attest that this Medication will not be offered for sale, trade, or barter. I understand that Lilly Cares has the right to contact the patient directly to confirm receipt of the Medications, and to revise or terminate the Program at any time. I further attest that all Medications previously received from Lilly Cares and distributed by me were distributed only to Qualifying Patients. I agree to properly dispose of any unused Medication.

I authorize Lilly Cares to act on my behalf for the limited purposes of transmitting this order for prescription medication.

Signature: _____ _____
Dispense as written **Substitution/brand exchange permitted**
Rubber stamps, signature by other office personnel for the prescriber, and computer-generated signatures will not be accepted.

Date: _____ License # PA-818 State of licensure: _____

DEA # MN2053382 (as required) Telephone: (208)528-7655 FAX: (208)524-9390

Shipping information (NO PO BOX or THIRD PARTY VENDOR): Prescriber Name and Title: Ms. Rebecca Newby PA-C

Prescriber's Office/Clinic Name: COMMUNITY FAMILY CLINIC

Address: 2088 E. 25th Street

City: Idaho Falls State: ID Zip: 83404